Client #_____ **Verification of Client ID**_____

NEW YORK STATE OF OPPORTUNITY. | **Department of Civil Service**

EMPLOYEE HEALTH SERVICE

Client Data and Consent for Medical Examination

EHS-722 (4/2019L)

FOR EHS OFFICE STAFF ONLY:

TYPE OF EXAMINATION:

OH #_____ ☐ **REINSTATEMENT** ☐ **55 B/C**

☐ **AGENCY REFERRAL** ☐ **PRE-PLACEMENT** ☐ **OTHER**_____

TYPE OF TESTS:

☐ **VS/MD** ☐ **COMP.** ☐ **PULMONARY** ☐ **ASB. F/U** ☐ **URINE DRUG**

☐ **NOISE** ☐ **LEAD** ☐ **CHOLINESTERASE** ☐ **ABILITY** ☐ **PSYCH. ONLY**

☐ **ROUTINEBLOOD** ☐ **MMPI / Bio** ☐ **BLOOD ALCOHOL** ☐ **ASB/X-RAY** ☐ **OTHER**_____

CLIENT SHOULD COMPLETE THIS AREA (*Please print clearly*)

Last Name	*First Name*	*M.I.*	*SSN or EHS Acct No.*	*Date of Birth*	*Age*

Address *Street*	*Sex* ☐ *Male* ☐ *Female*

City or Post Office	*County*	*State*	*Zip Code*	*Cell Phone* ( )

Have you previously been examined by the Employee Health Service?	*Home Phone*
☐ *Yes* *If Yes, when?*_____ ☐ *No*	( )

FILL IN THIS SECTION ONLY IF YOU ARE CURRENTLY A STATE EMPLOYEE

Position Title (Either present or title that you are applying for.)	*State agency name and address where presently employed.*

CONSENT FOR EXAMINATION AND RELEASE OF MEDICAL INFORMATION

I hereby consent to receive a medical examination and authorize the New York State Department of Civil Service Employee Health Service, its personnel, medical staff and consultants to perform such medical examinations and diagnostic procedures as deemed necessary for evaluation and/or treatment of any health condition.

I authorize the Department of Civil Service to release or disclose the following medical information to the agency/facility where I am employed:

1. Confirmation or denial of my ability to participate in various workplace programs and/or to use personal protective gear.
2. Occupational-related outcomes or adverse health effects as a result of workplace exposures as required by O.S.H.A.

I received a copy of the EHS Notice of Privacy Practices _____
(Initial)

Client's Signature*_____ Date _____

Print any other last name by which you have been known:_____

***NOTE:** Clients under the age of 18 cannot sign the **CONSENT FOR EXAMINATION**; they must submit form EHS-794, Authorization and Consent for Examination and Treatment of Minors.

Unless revoked, this authorization will expire in 180 days. You may revoke this authorization by writing to the EHS Privacy Official at the address at the top of this page unless the EHS has already disclosed the information for the purpose(s) noted above. This information may be re-disclosed by the recipient and no longer be protected under federal law. ***Please be sure you receive a copy of this authorization after you sign it.***

PERSONAL PRIVACY PROTECTION NOTIFICATION - **The information you provide on this form is being requested for the principal purpose of conducting a physical, medical and/or mental evaluation. The information will be used in accordance with section 96 (1) of the Personal Privacy Protection Law. Failure to provide the information may interfere with our ability to perform such evaluation and report our findings. This information will be maintained by the Administrator of the Employee Health Service, Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, NY 12047; telephone (518) 233-3100. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.**

THIS SIDE SHOULD BE COMPLETED BY THE EHS PHYSICIAN

PRE-PLACEMENT EXAMINATIONS – Final Disposition

- ☐ **Qualified** _____ **Examiner's Initials / Date**
- ☐ **Disqualified (see below)** _____ **Examiner's Initials / Date**
- ☐ **Incomplete (see below)** _____ **Examiner's Initials / Date**

ABILITY TEST: _____ **Passed** ☐ **N/A**

- ☐ **Failed first attempt**
- ☐ **Passed second attempt**
- ☐ **Failed second attempt - Disqualified**
- ☐ **Incomplete**

DRUG SCREEN: _____ **Negative** ☐ **N/A**

- ☐ **Needs MRO review**
- ☐ **MRO confirmed negative drug screen**
- ☐ **MRO confirmed positive drug screen - Disqualified**
- ☐ **Needs repeat drug screen**
- ☐ **Incomplete**

PSYCHOLOGICAL SCREEN: _____ **Passed** ☐ **N/A**

- ☐ **Needs psychological evaluation**
- ☐ **Cleared first psychological evaluation**
- ☐ **Not cleared first psych eval. – Schedule 2nd evaluation**
- ☐ **Cleared second psychological evaluation**
- ☐ **Not cleared 2nd evaluation - Disqualified**
- ☐ **Incomplete**

MEDICAL EVALUATION: _____ **Passed**

- ☐ **Remediable:**
- **#1** _____ ☐ **Cleared**
- **#2** _____ ☐ **Cleared**
- **#3** _____ ☐ **Cleared**
- **#4** _____ ☐ **Cleared**
- ☐ **Disqualified**
- ☐ **Incomplete**

FOLLOWING REPORTS TO BE SENT

EHS-797 Letter:

- ☐ **"Within Normal Limits" Letter**
- ☐ **"Discuss with Physician" Letter**
- ☐ **Client**_____
- ☐ **No Letter/Reports to be Sent**

- ☐ **Blood Chemistry/Hematology/Urinalysis**
- ☐ **Chest X-ray (Rpt.)**
- ☐ **ECG**
- ☐ **Hearing**
- ☐ **Physical Exam (including vital signs)**
- ☐ **Pulmonary Function**
- ☐ **Vision**
- ☐ **Other**

Examiner's Initials: _____ **Date:** _____

Reports Sent By: **Date:** _____

_____